KELLOGG & SOVEREIGN CONSULTING, LLC

Universal Service Management Professionals

February 1, 2018

Ajit Pai, Chairman
Mignon Clyburn, Commissioner
Michael O'Rielly, Commissioner
Brendan Carr, Commissioner
Jessica Rosenworcel, Commissioner
Federal Communications Commission
445 12th Street, SW
Washington, DC 20554

Submitted via: http://www.regulations.gov
http://apps.fcc.gov/ecfs/

RE: Comments on WC Docket No. 17-310 Notice of Proposed Rulemaking (NPRM) and Order

Dear Chairman Pai and Commissioners,

Kellogg & Sovereign® Consulting, LLC ("KSLLC") submits these Comments in response to the FCC's Notice of Proposed Rulemaking and Order, released December 18, 2017.

The professionals with KSLLC have been managing RHC applications on behalf of healthcare entities since 2007 and E-rate applications since 1998. In FY 2017, KSLLC managed applications for over 600 E-rate and RHC applicants. The E-rate applicants range in size from a single building in a small rural town to large urban districts and everything in between. The RHC applicants range in size from small rural healthcare providers to regional consortia, and large urban hospital systems.

The firm's diverse client base provides KSLLC with a unique perspective to share the successes and challenges faced by various types and sizes of applicants in securing funding from the RHC and E-rate programs. These programs are vitally important to meeting the needs of the applicants by providing affordable access to healthcare services and, in the case of schools, to curriculum resources in the cloud.

We commend the Commission for opening this Proposed Rulemaking and Order to ensure that rural healthcare providers continue to get the support the RHC programs provide. We urge the Commission to use this proceeding as an opportunity to improve the operation and efficiency of the RHC programs, provide necessary funding to the program, and to find additional safeguards against waste, fraud and abuse. We also support seeking additional ways to deliver cost -effective healthcare regardless of whether an HCP is in a rural area or an urban area entity providing on-time delivery of healthcare services in support of rural providers.

III. Notice of Proposed Rulemaking

A. Addressing RHC Program Funding Levels

1. Revisiting the RHC Program Funding Cap

15. FY2017 Funding Cap

In FY2016, the demand from both programs exceeded the $400 million cap for the first time in the Program's history, resulting in proration of support for applicants. Although funding has not yet been committed for FY2017, raw data from USAC indicates that FY2017 demand will also exceed the current $400 million cap.

16. Support for Increasing the Funding Cap

With the continued increase in demand for this valuable program and positive changes in the program itself with the addition of the Healthcare Connect Fund, we support the recommendation to significantly increase the $400 million cap to sufficiently meet the demand of the program for both current and future needs.

Telehealth a necessity for delivery of health care

A study published by InMedica Research in 2013 states that *"Telehealth revenues are also predicted to increase from $174 million last year to over $700 million in 2017. As doctors look for ways to grow patient engagement and increase revenue, telehealth is proving more appealing as a solution."*[1]

Another study conducted by The Advisory Board in 2015 and updated in 2017[2] details some of the drivers in demand as the following:

- *There will be increasing oversight of readmission of patients to hospitals which will drive providers to adopt Telehealth.*
- *Providers will increase the usage of telehealth as healthcare providers insist on using the service to increase their ties to patients and improve the quality of service*
- *Insurance providers will promote telehealth as a way to increase their competitiveness and lessen in-patient payouts by working with suppliers in monitoring their clients*
- *Consumers will actively seek and request telehealth services. This will continue to be the preferred medical service by patients in rural or non-metropolitan locations. where there's a low availability of clinics and doctors.*

With the rise in demand for better and high-tech healthcare services, Telehealth growth in 2017 will continue. This is a vital technology in the medical sector as it enables reaching out to patients living in remote areas and those who are in need of need of cost-effective solutions for medical care.

As stated in the studies above, delivery of services using telehealth is becoming a necessity for providers and is no longer an optional service. Health care providers are seeking funding sources to afford quality telemedicine healthcare delivery. As these providers learn about the funding provided by the FCC's Rural Health Care programs, a significant increase in demand on the RHC program has and will continue to occur. The HCPs will continue to seek funding for the foreseeable future.

[1] *See InMedica, Predicting Six Times Growth* http://www.mobihealthnews.com/tag/inmedica-research
[2] *See Four drivers in demand* https://www.beckershospitalreview.com/telehealth/4-trends-driving-telehealth.html

Medical-Grade Bandwidth Demand

Additionally, to expand telehealth services, there has been exponential growth in demand for medical-grade bandwidth, with most providers seeking upgrades to broadband circuits every year. Many HCPs are adding additional rural locations with connectivity to urban locations to reach more patients in outlying areas.

We support the comments submitted by the *Schools, Health & Libraries Broadband Coalition (SHLB)* that provide a comprehensive overview of the forces driving the increasing demand for RHC services.

HCF Program Growth Demand

A large driver of demand in the RHC fund is the new opportunities provided to all eligible providers under the Health care Connect Fund (HCF) program beginning in January 2014. The chart below is a comparison of eligible services under the HCF fund showing the differences between filing as an individual or filing as a consortium.

When the ability to include urban providers in consortia became available, several large state agencies requested the new funds to connect with their outlying hospitals and clinics in one seamless network which enabled them to deliver more telehealth services than ever before.

HCPs have found that the HCF is a better solution because they can file as a consortium and include urban sites that provide essential services and resources for the rural sites. They are also able to receive better pricing with volume discounts and the administrative burden is minimized by filing only one application instead of many. Both individual and consortium HCPs also receive a flat 65% discount so the urban rate search is eliminated. The HCF allows for more reliable budgeting for planning purposes regarding telemedicine circuits and network equipment for network operations and special construction of the network. The added ability to request three years of funding on one application cuts down on administrative time and cost while still seeking the most cost-effective solutions. The advantages of the HCF Program has resulted in an increase in demand; however, it has also resulted in better telehealth services, both technically and through the facilitation of connecting more urban specialists with rural health patients needing care.

	FCC HEALTH CARE CONNECT FUND[1]	
	INDIVIDUAL Applicants	**CONSORTIUM Applicants**
Eligible Services	Any advanced telecommunications or information service that enables HCPs to post their own data, interact with stored data, generate new data, or communicate, **by providing connectivity over private dedicated networks or the public Internet for the provision of health information technology.**	
Support provided	65%	65%
Reasonable & Customary Installation Charges (≤$5,000 undiscounted cost)	✓	✓
Lit Fiber Lease	✓	✓
Dark Fiber		
• Recurring charges (lease of fiber and/or lighting equipment, recurring maintenance charges)	✓	✓
• Upfront payments for IRUs, leases, equipment	NO	✓
Connections to Research & Education Networks	✓	✓
HCP Connections Between Off-Site Data Centers & Administrative Offices	✓	✓
Upfront Charges for Deployment of New or Upgraded Facilities	NO	✓
HCP-Constructed and Owned Facilities	NO	✓
Eligible Equipment		
• Equipment necessary to make broadband service functional	✓	✓
• Equipment necessary to manage, control, or maintain broadband service or dedicated health care broadband network	NO	✓

[1] Section V - FCC Health Connect Fund Report & Order, Released December 21, 2012 (see page 51, Paragraph 106)

With the success of the four years of the HCF, many other state agencies are looking at applying in upcoming years due to the increased demand for telehealth in their rural locations. It is anticipated that more and more HCPs will form consortia, which will increase the demand on the program.

18. Increasing the Cap, How Much?

The FCC, USAC, HCPs and service providers alike have discussed possible solutions for increasing the funding cap. Many have recommended various amounts that would be sufficient to fund all applications for each of the next few years and into the future. A common recommendation is to double the fund to $800 million or more. We agree that the cap should be increased to $800 million at a minimum. In addition to increasing the funding cap, we support using the GDP-CPI to adjust for inflation.

We support the comments submitted by the Schools, Health & Libraries Broadband Coalition (SHLB) that provide a comprehensive evaluation of factors to consider in raising the RHC program funding cap.

19. Rollover of unused funds to subsequent funding years.

Due to the exponential growth of the RHC program, we support the Commission's recommendation to adopt a process of rolling over unused funds into the next funding year. It is our understanding that to-date, unused funds have not been rolled over, but factored into the assessment factor to maintain a lower quarterly fee assessment. This was sufficient in the years when the RHC program had not exceeded the cap; however, now that demand has exceeded the cap for two years, unused funds should be rolled over to the next fund year in order to provide the needed support for HCPs and meet the RHC program goals.

20. Funds should be provided in upcoming years without prioritization. In the E-rate program, unused funds have been essential in enabling more applicants to receive full funding for vital programs than they would have had without rollover of unused funds. The E-rate program applies the additional funds across the board rather than prioritizing distribution. For example, specifying that funds will go to rural healthcare providers who chose to file individually would effectively penalize rural healthcare providers who chose to participate in a consortium. Additionally, prioritization of rollover funds would add an additional layer of complexity in management of the

program. If priority is given to individual filers, for example, there would be an unintended consequence of reducing consortium participation.

2. Prioritizing Funding if Demand Reaches the Cap

24. Prioritization Based on Rurality or Remoteness.

Rurality or remoteness alone does not indicate the highest need for funding. In the E-rate program, for example, the highest need is determined by the rural status of a school combined with the percent of low income students. Schools located in a rural area with a low income of 75% or greater receive the highest discount rates. This combination of rurality and low income effectively identifies the applicants with the greatest need.

For the RHC programs, we support the recommendation that rurality should not be used as the only consideration of need, but that the program use a federal standardized measure of need, such as Medicaid, in combination with rurality to determine the HCPs with the greatest need.

30. Modification of Term 'Rural'.

We support a definition of rurality that does not add additional complexity to the program.

31. Prioritizing Based on Type of Service.

We support the recommendation that the highest priority be given to services that support the primary purpose of Universal Service to provide affordable access. Therefore, the highest priority should be given to telecommunications and information services. Additionally, support for up-front costs and network build out should be a second priority as these one-time costs are often necessary to reduce costs of telecommunications and information services over the long term.

28. Priority based on RHC Program.

We promote phase out of the Telecommunications Program to place all applicants on the same playing field, using unified rules and transparency. The HCF was developed over years of research and study with the Pilot Program and its principles provide the best support for Universal Service.

The statutory language of 47 U.S.C. §254(h)(1)(A) and § 254(h)(2)(A) of the Act gives specific instruction that was the basis for the creation of the Telecommunications Program; however, § 254(b)(7) states:

> *ADDITIONAL PRINCIPLES. --Such other principles as the Joint Board and the Commission determine are necessary and appropriate for the protection of the public interest, convenience, and necessity are consistent with this Act.*

KSLLC interprets this section to allow additional authority to the Commission, giving latitude for them to provide equal funding emphasis the Healthcare Connect Fund. As stated in Item 22, funding should be disbursed first for essential services; however, we do not recommend setting aside or prioritizing certain amounts of funding for one or the other programs. Instead, we support phasing out the Telecommunications Program and continuing forward with one program.

33. Prioritizing Based on Economic Need or Healthcare Professional Shortages.

We feel that at this time, a prioritization based on economic need or healthcare professional shortages would be too subjective and not possible to implement.

34. Prioritizing Funding with Shortages.

We recommend the following strategies to prioritize funding with shortages:

1. Phase out the telecommunications program. Now that majority of services are no longer subject to tariff rates, the determination of rural vs urban rates is subjective. As shown by recent FCC cases, the methodology is open to waste, fraud and abuse. The flat 65% discount rate in the health care connect fund protects the fund from manipulation of the urban and rural rates and allows for a reasonable discount to provide needed support. Additionally, phase out of the telecommunications program will result in administrative cost savings. The administrative burden on the RHC program of maintaining two separate programs is significant.

2. Implement a prioritization of services - (a) telecommunications and information services; (b) up-front charges for deployment of new or upgraded facilities and the cost of self-provisioned networks and (c) the costs associated with the network operations of consortia.

The chart bellows identifies the recommended priorities for funding:

	FCC HEALTH CARE CONNECT FUND[1]		
	INDIVIDUAL Applicants	**CONSORTIUM Applicants**	**PRIORITY**
Eligible Services	Any advanced telecommunications or information service that enables HCPs to post their own data, interact with stored data, generate new data, or communicate, **by providing connectivity over private dedicated networks or the public Internet for the provision of health information technology.**		1
Support provided	65%	65%	
Reasonable & Customary Installation Charges (≤$5,000 undiscounted cost)	✓	✓	1
Lit Fiber Lease	✓	✓	1
Dark Fiber			
• Recurring charges (lease of fiber and/or lighting equipment, recurring maintenance charges)	✓	✓	1
• Upfront payments for IRUs, leases, equipment	NO	✓	2
Connections to Research & Education Networks	✓	✓	1
HCP Connections Between Off-Site Data Centers & Administrative Offices	✓	✓	1
Upfront Charges for Deployment of New or Upgraded Facilities	NO	✓	2
HCP-Constructed and Owned Facilities	NO	✓	2
Eligible Equipment			
• Equipment necessary to make broadband service functional	✓	✓	1
• Equipment necessary to manage, control, or maintain broadband service or dedicated health care broadband network	NO	✓	3

3. Targeting Support To Our Rural and Tribal Health Care Providers

37. Rural health care participation of 50% or more

In our experience working with 28 consortia over the past three years, we feel that the current requirement has worked well. Requiring a larger percentage would prevent some small consortia from receiving the benefits of being a part of a consortium.

38. Three-year grace period for Consortium Rural %

For new consortia, we have found that it typically takes longer than one or two years to establish the participants and ensure a proper balance. Many of these consortia are established due to a growth in their existing healthcare system, which sometimes takes several years to facilitate. Consortia leaders are typically located at the urban sites since they have the administrative support; therefore, the urban locations initiate the consortium and it takes at least three years to establish the contracts and then start adding rural participants.

39. Direct Healthcare-Service Relationship.

Including both urban and rural health care providers in the same consortium will, by definition, involve interaction of the health care professionals in support of telehealth throughout the organization. This relationship by its nature directly benefits the rural health care providers. Adding requirements for consortia to prove that urban providers are directly supporting the rural participants could negatively impact the collaborative nature and organic growth of a consortium. Therefore, we do not support any additional requirements to prove that the urban providers are directly supporting the rural participants.

40. Rural and Tribal Healthcare Providers.

Targeted support for health care providers on tribal lands should continue to be an important priority of the program. Health care providers located on tribal lands represent a minimal but very important portion of the fund as these areas tend to be rural and underserved.

B. Promoting Efficient Operation of the RHC Program to Prevent Waste, Fraud, and Abuse

1. Controlling Outlier Costs in the Telecom Program

42. Outlier Funding Requests.

We agree that establishing an objective benchmark to identify those outlying funding requests will provide greater transparency for RHC Program participants and clearer guidance to USAC.

3. Defining the "Cost-Effectiveness" Standard Across the RHC Program

82. Cost-Effectiveness Standard

We believe the Commission should implement the use of the current HCF competitive bidding requirements as outlined in the HCF Order in §54.642 4(c)[3] for all RHC participants. These requirements are complete and would provide additional bid requirements not currently existing in the Telecommunications Program. This would bring the two programs closer together and provide vendors with clear guidelines for both RHC programs.

<u>Step 3 Prepare for Competitive Bidding</u>

- Develop Evaluation Criteria
  - Cost
  - Bandwidth
  - Quality of Transmission
  - Reliability
  - Technical Support
  - Etc.
- Prepare a Request for Proposal as defined below:
  -A request for proposal (RFP) is a formal bidding document that describes a project and requests services in sufficient detail so that potential bidders understand the scope, location, time frame,

[3] *See* [582] 47 C.F.R. §§ 54.603(b)(3), 54.615.

and any other requirements.[4]

84. Detailed Requests

We support a requirement that all RHC participants be required to provide specific, detailed information on their needs for eligible services in their RFP and /or requests for services. All applicants should also provide the same amount of transparency that the HCF program currently requires for the bidding process. For example, all HCPs should use a scoring matrix to evaluate all bids and provide copies of all bids received during the competitive bidding period. All scoring matrices and bids should be included at the time of the funding request as is required in the HCF. For administrative efficiency and timeliness of funding, the program administrator will need to have discretion over the internal procedures used to manage in-depth analysis of information submitted and approval of funding based on internal review standards.

C. Improving Oversight of the RHC Program

1. Establishing Rules on Consultants, Gifts, and Invoicing Deadlines

a. Establishing Rules on the Use of Consultants

87. Consultants

We applaud the Commission's proposal to adopt specific requirements that will give consultants well-defined boundaries as they guide applicants through the HCF Program funding process.

The E-rate program has included compliance in all training programs for applicants, consultants and service providers since 2010. This training includes and clearly states the role of Applicants, Service Providers, and Consultants regarding each type of entity and their role:

- Applicant Role
    - Write technology plan, prepare federal competitive bidding forms and request for proposals, evaluate bids, select provider, document the process, file forms for funding support, and select invoicing method

[4] *See Request for Proposal* http://www.usac.org/rhc/healthcare-connect/individual/step03/default.aspx

- Service Provider Role
    - Respond to competitive bidding requests, provide vendor documentation, provide technical answers on questions regarding specific goods and services requested, (but NOT on competitive bidding); submit invoices as directed to program administrator
- Consultant Role
    - Follow the role of their client – either applicant ***or*** service provider

In 2010, the E-rate program began requiring consultants to apply for and use a Consultant Registration Number (CRN). Applicants then enter the CRN in their online forms to provide transparency on all E-rate applications.[5]

USAC guidance in 2014 provided the following information regarding the role of the consultant as follows:

- Obtain a Consultant Registration Number to be included on all FCC forms where you provide assistance to schools and libraries with their E-rate applications for a fee.
- Follow the role of your client – either applicant or service provider.
- Avoid conflicts of interest.
- Document your compliance with FCC rules on an on-going basis.
- Retain documentation for at least five years from last date of service delivery. *(Note that documentation requirements for E-rate are now ten years from the last date of service delivery).*

As a consultant, we recommend the Commission codify similar recommendations and suggest that they be implemented as soon as possible.

Service Providers. We strongly urge the Commission to require service providers to disclose the names of any consultants or third parties who helped them identify the healthcare provider's RFP or helped them to connect with the healthcare provider in some other way.

In the E-rate 2014 training slides quoted above, the following states the Role of the service provider:

- Respond to FCC Forms 470 and RFPs, once they have been issued.

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[5] *See Consultant Requirement* http://www.usac.org/sl/applicants/step01/consultant-registration-numbers.aspx

- Assist applicants with preparing their FCC Form 471 Item 21 attachments.
- Provide technical answers on questions regarding specific goods and services requested but NOT on competitive bidding questions.
- File FCC Form 473, Service Provider Annual Certification Form.
- File FCC Form 474, Service Provider Invoice, if applicable.
- Document your compliance with FCC rules on an on-going basis.
- Retain documentation for at least five years from last date of service delivery. *(Note that documentation requirements for E-rate are now ten years from the last date of service delivery).*

b. Establishing Consistent Gift Restrictions

90. Gift Restrictions – Who does this apply to?

We agree that the FCC should codify gift rules for the RHC programs like the rules established for the E-Rate program and federal entities. Once clearly outlined gift rules are implemented, applicants who receive offers from service providers can point to clear rules that allow them to say no and avoid questionable activity that might influence their buying decisions. Gift rules should apply to applicants, service providers, and consultants.

93. Gift Restrictions – When does it apply?

We support the adoption of gift restrictions that are applicable year-round. This avoids "grey areas" in gifting throughout the year. We also support a certification by applicants that they have not solicited or accepted a gift or any other thing of value from their selected service provider or any other service provider participating in their competitive bidding process. We support rules that will also require a certification from the service providers as well.

2. Streamlining the RHC FCC Forms Application Process

97. Streamlining FCC Forms.

We recommend that the FCC streamline the forms as recommended in the NPRM. This would reduce the complexity of specific forms for each of the RHC programs and make them easier to complete by the Healthcare providers.

"*The Commission proposes to use four forms—Eligibility Form, Request for Services Form, Request for Funding Form, and Invoicing/Funding Disbursement Form*."

We fully support the recommendation to simplify the forms.

Additionally, the continuation of the Telecommunications Program creates an undue burden on the administration of the program. Phasing out the telecommunications program would greatly alleviate the multiple forms issues that are being managed by the limited staff and the program stakeholders.

98. Consortia Processing

We support SHLB statements that the Commission improve the processing of consortia applications and find ways to speed the processing of the various FCC HCF forms and streamline the treatment of individual health care sites. The 8-month delay for FY 2017 applications has created a huge financial burden on HCPs, most who are already struggling financially.

3. Applying Lessons Learned from the HCF Program to the Telecom Program

a. Aligning the" Fair and Open" Competitive Bidding Standard

100. "Fair and Open".

We agree that the Commission should align the "fair and open" competitive bidding standard applied to each Program. We also support the application of the "fair and open" standard to all participants under each RHC Program, including applicants, service providers, and consultants, and require them to certify compliance with the standard.

b. Aligning Competitive Bidding Exemptions in Both RHC Programs

101. Proposed Exemptions

We support the phase out of the Telecommunications Program which would eliminate the duplicate processes currently managed by the limited administrative staff. During the phase out period, we support the alignment of all rules for both RHC programs as stated several times above. In doing so, they should also adopt the E-rate program guidelines which have been successfully implemented during the past twenty years of the E-rate program.

We support using the following as exemptions in the RHC program for all participants, as was proposed in the NPRM: (1) Applicants who are purchasing services and/or equipment from master services agreements (MSAs) negotiated by federal, state, Tribal, or local government entities on behalf of such applicants; applicants purchasing services and/or equipment from an MSA that was subject to the HCF and Pilot Programs competitive bidding requirements; (3) applicants seeking support under a contract that was deemed "evergreen" by USAC; and (4) applicants seeking support under an contract that was competitively bid consistent with ERATE Program rules.

c. Requiring submission of documentation with requests for services

93. Competitive Bidding Documentation.

We believe that all participants in RHC Program should be required to provide the same competitive bidding documentation required in the HCF Order. The current difference in requirements creates inequity in accountability. We support phasing out the Telecommunications Program to put all participants on the same level playing field for accountability.

The documentation process should remain unchanged for HCPs filing with a competitive bid exemption. It would be difficult for HCPs filing with an exemption using a tribal exemption or state master contract when they are not directly involved in the procurement process.

d. Requiring Submission of Documentation with Funding Requests[6]

103. Telecom Requirements

Again, we emphasize our support for phasing out the Telecommunications Program to put all participants on the same level playing field for accountability. We support codifying filing documentation requirements for all RHC participants that matches the requirements for the HCF Program to improve uniformity and transparency.

e. Unifying Data Collection on RHC Program Support Impact

104. RHC Program Reporting.

We recommend that the participants in the RHC program should be required to report annually on the telehealth applications provided over the supported connections.

4. Managing Filing Window Periods

106. Filing Windows. We support the continuation of the current filing window period established by the Bureau and USAC for administering FY 2017 HCF Program funds. Set filing periods make it easier for the applicant to plan accordingly.

We also believe that applications should be reviewed as they are submitted and USAC should issue Funding Commitment Letters as reviews are completed.

Additional Comments:

PROGRAM TRANSPARENCY

The RHC program only provides "lip service" to the FCC's requirement for program transparency. There is basically no reporting available in the RHC program. This is in stark contrast to the E-rate program that allows program stakeholders to download and review extensive E-rate program data. The E-rate program actively participates in the open data source program and provides detailed information in downloadable format with their data retrieval tool, funding commitment tool, 470 and 471 tools.

Without the ability to download RHC program data, stakeholders in the program must operate by creating their own data management tools without the ability to cross check with USAC program data. There is not a way to determine total disbursements on a funding request, remaining funds on a funding request, due dates, and forms that need to be filed and upcoming deadlines. Additionally, consortium leaders do not have a way to easily view multiple HCPs on a single report.

We strongly urge the FCC to adopt the same transparency guidelines implemented in E-rate that requires all participants to agree to price transparency. As the Universal Service Fund is generated as a fee assessed to service providers and passed on to ratepayers, transparency should be foundational to the programs for continued integrity. We have included a snapshot below extracted from 47 U.S.C. § 54.504

> (2) All pricing and technology infrastructure information submitted as part of an FCC Form 471 shall be treated as public and non-confidential by the Administrator unless the applicant specifies a statute, rule, or other restriction, such as a court order or an existing contract limitation barring public release of the information.
>
> (i) Contracts and other agreements executed after adoption of this rule may not prohibit disclosure of pricing or technology infrastructure information.
>
> (ii) The exemption for existing contract limitations shall not apply to voluntary extensions or renewals of existing contracts.

Closing Remarks

In closing, Kellogg & Sovereign® thanks the FCC for its attention to the immediate and long-term needs of the Rural Health Care Program. We look forward to working with the FCC through this process in the coming months.

We conclude with five key points that we believe are important to ensuring the future viability and success of this program:

- Increase the funding cap to meet the present demand and project for future demand
- Provide predictable funding by implementing established filing windows
- Increase transparency of the Program by requiring USAC to provide access to data in downloadable format
- Phase out the Telecommunications Program, allowing for simplification and administrative efficiencies
- Continue Healthcare Connect Fund principals that have made it so popular and valuable since its inception in 2014

Respectfully submitted,

Deborah Sovereign, CPA
Kellogg & Sovereign® Consulting, LLC
580-559-8302